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BERNADETTE McSHERRY and IAN FRECKLETON (eds.), *Coercive Care: Rights, Law and Policy* Oxford, Routledge, 2013, 340 pp., Hardback, £90, ISBN 9780415628198, 2015; Paperback, £29.99, ISBN 9781138935006

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Coercive care remains predominant in the treatment of mental ill health. It is distinctive as one of the very few areas of medical practice where overtly paternalistic traditions still dominate, and patients can be admitted compulsorily to hospital and forcibly treated, irrespective of their mental capacity or individual autonomy. Undoubtedly, the use of coercion in this way is ‘hotly ‘contested’ (p. 5), particularly in an era where patient autonomy and human rights are increasingly at the forefront. Inevitably, this creates tension and forces us to re-examine conventional approaches to the treatment of mental ill health, and this edited collection seeks to do just that.

Contributors to this collection explore the concept of coercion and present a challenge to it as a legitimate way of providing care to mentally ill individuals. The advent of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) has provided further impetus to this challenge. The CRPD clarifies the obligations on State Parties to promote and ensure the rights of persons with disabilities. To date, it has 159 signatories, including most of the jurisdictions which are considered in this edited collection.<sup>1</sup> Significantly, the CRPD adopts a social model of disability, viewing people with disabilities as subjects who deserve equal recognition and respect. This approach stands in contrast to the medical model, which views people with disabilities as objects who are afflicted by their illness and require protection and sympathy. The medical model strongly influenced the United Nations Principles for the Protection of Persons with Mental Illness, which were adopted in 1991, and are now regarded by many as outdated and inappropriate, focusing as they do on treatment and protection. The new CRPD rights-based approach posits that disabilities are the result of barriers created by society, ‘the social model of disability locates the experience of disability in the social environment, rather than the impairment’.<sup>2</sup> Consequently, there is a need for signatories to the CRPD to take ‘action to dismantle the social and physical barriers to the inclusion and participation of persons with disability’.<sup>3</sup>

As a result of its enabling and empowering ethos, the CRPD focuses in its General Principles on concepts such as human dignity, individual autonomy, non-discrimination, accessibility, equality of opportunity, full and effective participation and inclusion in society. These principles are clearly at odds with the use of coercion in mental health care. Consequently, there are significant challenges to implement the CRPD for those State Parties who still permit compulsory treatment for people on the basis of their mental disability, particularly in terms of Article 12 of the Convention. This Article guarantees the right to equality before the law for people with disabilities, on an equal basis with others. It has been interpreted by the Committee on the Rights of Persons with Disabilities as implying ‘a shift from the substitute

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<sup>1</sup> The Convention on the Rights of Persons with Disabilities and its Optional Protocol (A/RES/61/106) was adopted by the General Assembly on 27<sup>th</sup> January 2007- located at <http://www.un.org/disabilities/> (Accessed 6<sup>th</sup> September 2015). The CRPD’s 159 signatories to date include Australia, New Zealand, Canada, the United States of America and the United Kingdom – all of which are considered in contributions to this edited collection.

<sup>2</sup> R Kayess and P French, ‘Out of darkness and into light? Introducing the Convention on the Rights of Persons with Disabilities’ (2008) 8 *Human Rights Law Review* 1, 6.

<sup>3</sup> Ibid.

decision-making paradigm to one that is based on supported decision making'.<sup>4</sup> The Committee has also made it clear that Article 12 implies the need to ensure that the legal capacity of persons with disabilities is not denied, therefore "unsoundness of mind" and other discriminatory labels are not legitimate reasons for the denial of legal capacity ... perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity'.<sup>5</sup>

The editors of this collection acknowledge that the CRPD is 'playing an increasingly important role in international discourse about human rights and disabilities' (p. 4), and it is used in many of the chapters as a 'human rights lens' (p. 3) through which to assess traditional coercive approaches. The unifying aim of this collection is to advocate for methods that promote the ethos of the CRPD by empowering patients and giving them a stronger voice. Bernadette McSherry and Ian Freckleton suggest that this will, in turn, at least minimise (if not eliminate) the use of coercion (described as the 'counter therapeutic and abusive use of force' (p. 3)) in mental health care.

This collection brings together contributions from a range of disciplines and jurisdictions, though the focus is predominantly on common law countries, including England and Wales, North America, Canada and Australia, all of whom are signatories to the CRPD. Comparable developments have occurred within these states during the last few decades; however, worryingly, they have all witnessed an expansion in the use of compulsion and coercive care, both within and without hospital walls. This has been accompanied by an increased focus on the concepts of risk and dangerousness in the compulsory treatment process. This clearly runs counter to the principles and aims of the CRPD. Consequently, this edited collection is a timely re-examination and challenge to that trend. The chapters are loosely grouped together around four main themes, conceptual frameworks, concepts of legal capacity and best interests, coercive care in the community, and coercion in the criminal justice system.<sup>6</sup>

In one of the early chapters, Penelope Weller helpfully sets the scene by examining developments throughout the last few decades.<sup>7</sup> She argues that, in the light of the CRPD, we need to establish a new conceptual framework which focuses on the individual patient and his/her subjective experience, and move away from risk and dangerousness as the key criterion for the use of compulsion. Thus, 'we must proceed from the assumption that a resort to coercion represents a failure of care' (p. 30). She maintains that there is an inherent tension between care and coercion, and that we now need to embrace a human rights framework and promote a model of mental health care based on partnership, which is, of course, increasingly prevalent in other areas of health care provision. This, Weller argues, will empower mental health patients and promote the spirit of the CRPD. This participation theme is explored further by Janet Lord and Michael Ashley Stein, who argue that the CRPD challenges the human rights advocate to embrace a conceptualisation of autonomy that allows for the valuing of positive rights/freedoms, and greater focus on individual autonomy.<sup>8</sup> The voices of persons with disabilities are getting louder, and mental health care providers must

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<sup>4</sup> General Comment No. 1 (2014) CRPD/C/GC/1 (19 May 2014) para. 3.

<sup>5</sup> Ibid, para. 13.

<sup>6</sup> Part 1: Coercive Care: Rights, Law and Policy, Part 2: Conceptual Frameworks for Coercive Care, Part 3: Legal Capacity, 'Best Interests' and Coercive Care, Part 4: Coercive Care in the Community, Part 5: Coercive Care and the Criminal Justice System.

<sup>7</sup> 'Towards a genealogy of "coercive care"', Ch. 2.

<sup>8</sup> 'Contingent Participation and Coercive Care: Feminist and Communitarian Theories of Disability and Legal Capacity', Ch. 3.

now respond to that and increase the focus on the subjective experiences and wishes of those who receive it.

In contrast, Nicola Glover-Thomas shifts the focus back to risk, emphasising how pervasive it has been, particularly in its application to compulsory community treatment in England and Wales.<sup>9</sup> The findings of her research into risk perception/determination in mental health care have been documented elsewhere,<sup>10</sup> and in this chapter Glover-Thomas highlights the vagaries and problems with a risk-based approach in the use of community treatment orders. She argues that it has led to ‘broad professional discretion within the legislation’ which gives rise to ‘very real challenges in the ongoing debate about how human rights can be best protected’ (p. 171). Bernadette McSherry attempts to find an alternative solution to providing support and promoting patient rights in community settings.<sup>11</sup> She explains how autonomy and patient participation can be promoted in community-based services for individuals with coexisting disorders in Victoria, Australia. McSherry considers what lessons can be learned from the Multiple and Complex Needs Panel, a statutory body established under the Human Services (Complex Needs) Act 2003 to provide a means of formal legal sanction to co-ordinate service delivery to this particular group of individuals. Evaluation of such schemes has pointed to some successful outcomes, although overall they are costly and may not be attractive to those who commission services. Nevertheless, it is clear that they can promote service co-operation and information exchange, which can lead to improved service provision and outcomes for this particular group. Moreover, they shift the focus away from risk and coercion, towards collaboration and patient participation, as promoted by the CRPD.

Indeed, many of the contributors to this collection not only question the traditional coercive risk-based approach but also offer alternatives to it. For example, Rowena Daw considers the ‘fusion model law’<sup>12</sup>, initially proposed by John Dawson and George Szukler.<sup>13</sup> Fusion law has been described as a ‘radical proposal’ (p. 95), but by making incapacity and best interests the primary criteria for compulsory treatment (thereby shifting the focus away from risk) it ‘would limit significantly the use of compulsory powers for the treatment of mental illness and thereby change the mindset and the practice of all involved – especially professionals, policy-makers, service users and families’ (p. 95). This is clearly in line with the aims of the CRPD.

Another option would be to consider how the CRPD obligation to ensure reasonable accommodation could facilitate supported decision-making for people with psycho-social and intellectual disabilities, as Marcia Rioux, Joan Gilmour and Natalia Angel-Cabo explore in their analysis of the Colombian and Canadian capacity laws.<sup>14</sup> Elizabeth Perkins’ chapter, with Heulen Sheldrick, analyses how the best interests approach can be interpreted in a more subjective manner for stroke patients.<sup>15</sup> And Ian Freckleton’s chapter analyses the human

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<sup>9</sup> ‘Community Treatment Orders in England and Wales: Are These the Way Forward in Reducing Perceived Risk of Harm?’, Ch. 9

<sup>10</sup> ‘The age of risk: Risk perception and determination following the Mental Health Act 2007’ (2011) 19 *Med. L. Rev.* 581.

<sup>11</sup> ‘From Coercion to Coordination? The Role of the Law in Service Provision for Individuals with Coexisting Disorders’, Ch.10.

<sup>12</sup> ‘The Case for a Fusion Law: Challenges and Issues’, Ch. 6.

<sup>13</sup> See, for eg., G Szukler, R Daw and J Dawson, ‘A model law fusing incapacity and mental health legislation’ (2010) *Journal of Mental Health Law* 11.

<sup>14</sup> ‘Negotiating Capacity: Legally Constructed Entitlement and Protection’, Ch. 4.

<sup>15</sup> ‘Decisions about Best Interests in the Acute Stages of Stroke’, Ch. 8.

rights challenges in the treatment of individuals with brain injuries.<sup>16</sup> Echoing some of Perkins' findings in relation to stroke patients in the acute stages, Freckleton points to the need for improved awareness amongst all professionals involved 'of the pervasive but often subtle effects that brain injuries can have for decision-making' (p. 279). He also emphasises the need for better detection of this form of disability, effective review mechanisms, the provision of more extensive information, as well as shared-decision making and the adoption of 'inclusive and enabling' attitudes on the part of carers, 'so that the care provided is as minimally coercive and as collaborative as is practicable' (p. 280).

Kris Gledhill's chapter is timely,<sup>17</sup> in the light of the Supreme Court decision in England in *P v Cheshire West and Chester Council and Another* [2014],<sup>18</sup> and the recent controversy surrounding the Deprivation of Liberty Safeguards (DoLS) under the Mental Capacity Act 2005 in England and Wales.<sup>19</sup> He proposes an alternative model to the DoLS based on the guardianship regime which is already available under the mental health legislation in England and Wales. This would have the advantage of simplicity, thereby avoiding some of the debates about the meaning of 'deprivation' which have so recently taxed healthcare professionals, lawyers and the courts in England and Wales.<sup>20</sup> Some of these arguments about making greater use of guardianship are not novel,<sup>21</sup> but greater emphasis is placed in this chapter on the role of the European Convention on Human Rights and potential reach of the CRPD in these debates.

In a similar vein, Michael Perlin argues that therapeutic jurisprudence resonates closely with the CRPD by promoting an 'ethic of care' and focusing on patient dignity and human rights (p. 197).<sup>22</sup> Some readers will be familiar with the extensive literature on 'therapeutic jurisprudence' in American mental health courts,<sup>23</sup> and therapeutic jurisprudence initially emerged in the 1990s in American courts as a means of dealing with cases involving individuals with mental disabilities. It has subsequently expanded beyond that to embrace 'a new model for assessing the impact of case law and legislation', recognising that, as a therapeutic agent, the law impacts on and change people's lives (p. 196). Evidence from Mental Health Courts in the US suggests that they can promote dignity, and Perlin's chapter makes the point that the CRPD should be used by patient advocates as 'a launching pad for an international movement to create such courts' (p. 194). Other chapters in the criminal

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<sup>16</sup> 'Brain Injuries and Coercive Care: Human Rights Issues and Challenges', Ch. 14.

<sup>17</sup> 'The Filling of the "Bournewood Gap": Coercive Care and the Statutory Mechanisms in England and Wales', Ch. 7.

<sup>18</sup> [2014] UKSC 19.

<sup>19</sup> See, for eg, the House of Lords Select Committee Report, *Mental Capacity Act 2005: Post-Legislative Scrutiny*, Session 2013-14, HL Paper 139 (London: TSO, 2014) p 8: 'The intention behind the safeguards - to provide protection in law for individuals who were being deprived of their liberty for reasons of their own safety - was understood and supported by our witnesses. But the legislative provisions and their operation in practice are the subject of extensive and wide ranging criticism. The provisions are poorly drafted, overly complex and bear no relationship to the language and ethos of the Mental Capacity Act. The safeguards are not well understood and are poorly implemented. Evidence suggested that thousands, if not tens of thousands, of individuals are being deprived of their liberty without the protection of the law, and therefore without the safeguards which Parliament intended'.

<sup>20</sup> See, for eg, *JE v DE and Surrey County Council* (2006) EWHC 3459 (Fam); *P v Cheshire West* n 18 above.

<sup>21</sup> Phil Fennell, for eg, has argued that guardianship under the mental health legislation is preferable to using the complex safeguards: P Fennell, *Mental Health – The New Law* (Bristol: Jordans, 2007) Ch. 6.

<sup>22</sup> "'There Are No Trials Inside the Gates of Eden": Mental Health Courts, the Convention on the Rights of Persons with Disabilities, Dignity and the Promise of Therapeutic Jurisprudence', Ch. 11.

<sup>23</sup> See, for eg., M Perlin, *Mental Disability Law: Civil and Criminal* (Charlottesville VA: Lexis Law Publishing, 1998); DB Wexler, *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (Durham NC: Carolina Academic Press, 1990).

justice section of the book explore other alternatives, which shift the focus away from risk/coercion to patient autonomy and participation. For example, New Zealand's legislative provisions to protect offenders with intellectual disabilities, which are considered in two separate contributions by Warren Brookbanks and Kate Diesfeld.<sup>24</sup>

While many of the chapters seek to offer solutions, in some ways the book poses more questions than it answers, as McSherry and Freckleton acknowledge in their concluding chapter.<sup>25</sup> The CRPD is creating new dilemmas and the answers will not be quick or easy. Indeed, many State Parties are struggling to translate the CRPD into a reality, not least because it raises fundamental questions that are at variance with conventional wisdom and ingrained approaches about the provision of mental health care. However, there are encouraging signs that some domestic law reform bodies are grappling with these issues and trying to embrace the empowering philosophy of the CRPD. For example, the Australian Law Reform Commission produced a Report on *Equality, Capacity and Disability in Commonwealth Laws*, which has considered what changes could be made to Commonwealth law and legal frameworks to achieve equal recognition of people with disability as persons before the law and their ability to exercise legal capacity.<sup>26</sup> The Report recommends a new model of supported decision-making for the Commonwealth, based on the positions of 'supporter' and 'representative'. Crucially, emphasis is placed on the autonomy and independence of persons with disability who may require support in making decisions. Their will and preferences *must* drive decisions that they make and that others make on their behalf. Recent Law Commission proposals in England and Wales to replace the controversial DoLS system also endeavour to 'ensure as far as possible that our system is not only compatible with the UN Disability Convention, but is supportive of its aims and aspirations'.<sup>27</sup>

There are promising signs that the judiciary in England and Wales are increasingly mindful of the State's CRPD obligations and the philosophy which underpins them, as Lady Hale recognised in *P v Cheshire West* [2014]:

The rights set out in the European Convention are to be guaranteed to "everyone" (article 1). They are premised on the inherent dignity of all human beings whatever their frailty or flaws. The same philosophy underpins the United Nations Convention on the Rights of Persons with Disabilities (CRPD), ratified by the United Kingdom in 2009. Although not directly incorporated into our domestic law, the CRPD is recognised by the Strasbourg court as part of the international law context within which the guarantees of the European Convention are to be interpreted.<sup>28</sup>

The challenge, of course, will be translating these proposals onto statute books at a national level and into the daily practice of mental health workers. As Rioux, Gilmour and Angel-Cabo acknowledge, there are significant 'local challenges faced by persons with disabilities in gaining recognition of their legal capacity' as there are 'entrenched and grounded notions'

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<sup>24</sup> 'Managing the Challenges and Protecting the Rights of Intellectually Disabled Offenders', Ch. 12; 'Compulsory Care, Rehabilitation and Risk: The Expected and Unexpected Issues Raised by New Zealand's Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003', Ch. 13, respectively.

<sup>25</sup> 'Where to From Here for Coercive Care?', Ch. 15.

<sup>26</sup> Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (ALRC Report 124) (Sydney: Australian Law Reform Commission, 2014).

<sup>27</sup> Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper*, Consultation Paper No 222 (London: TSO, 2015) para 3.20.

<sup>28</sup> n 18 above [36].

as well as ‘presumptions’ about persons with disabilities to overcome.<sup>29</sup> Accordingly, they encourage us to remove the ‘blinkers’ in our approach to providing health care and treatment for individuals with mental disabilities (p. 75). That will require significant professional commitment and cultural shifts, which could well prove to be one of the biggest barriers to achieving change, as McSherry and Freckleton recognise: ‘how best in a practical sense can clinicians transcend the temptations of paternalism and work toward maximizing the capacity of those with disabilities’ (p. 286).

It is widely (though not universally) acknowledged that the need for coercive care in the treatment of mental health may never be completely eliminated, but:

[T]he challenge is to develop measures by which coercion in the clinical setting is minimized and whereby, when it has to be employed, a road back is found for the creation of a partnership directed toward dignity, respectfulness and collaborative provision of care. (p. 12)

This collection makes an important and thought-provoking contribution to the ongoing and broadening debate about how we can all work towards ensuring that persons with disabilities ‘can best identify their needs and capacities, assert their dignity and have their individual and collective voices heard’ (p. 286).

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<sup>29</sup> n 14 above, 75.